837 Institutional – Home Health claim form

This document is a field –by –field instructional help sheet. The fields are listed in a right to left format as they appear in the Provider Electronic Solution Software. Examples of the values needed in order to process the claim are given. Those fields with " Not Required" listed as a value, are present on the claim per HIPAA regulations and are not needed in order to process the claim. This software will **not** allow you to save a claim with a required field missing, however this does not guarantee that your claim will pay, just that the basic information is present. Auto populated fields have the valid value already present and do not need to be entered. ** Represents a list that must be created in order to process the claim. Please see attachment for directions on how to create the lists.

Header 1

FIELD	VALUE
Type of Bill	Appropriate for the claim you are billing
Provider ID **	Your 7 digit billing provider number (Hint: this is the # on the top left corner of your Remittance Advice
Taxonomy Code	Not Required
Last/Org Name	Will be auto populated when the provider number is selected from the provider list and then you hit the tab button on your keyboard
First Name	Will be auto populated when the provider number is selected from the provider list and then you hit the tab button on your keyboard
Client ID **	This is the MID (commonly the Social Security number) of the client you are billing services for
Account Number	Will be auto populated when the client number is selected from the client list and then you hit the tab button on your keyboard
Last Name	Will be auto populated when the client number is selected from the client list and then you hit the tab button on your keyboard
First Name	Will be auto populated when the client number is selected from the client list and then you hit the tab button on your keyboard
MI	Not Required
From DOS	The date you treated the client
To DOS	The date you stopped treating the client for this billing
Signature on File	Auto – Populated to Y = Yes
Patient Status	Choose a valid value from the drop down list. Commonly 30 = Still a patient
Medical Record #	Not Required
Benefits Assignment	Auto – Populated to Y = Yes
Release of Medical Data	Auto – Populated to Y = Yes
Report Type Code	Not Required

Report Transmission Code	Not Required

HEADER 2

Diagnosis Code: Primary Admit	Are the conditions for which you are treating the client i.e. 642 = Hypertension. These can be acquired from the clients Primary Care Physician or your medical records.
E -Code	Not Required
Attending Provider** SSN/Tax ID	The information will be auto populated when the provider number is selected from the other provider list and then you hit the tab button on your keyboard
Taxonomy Code	Not Required
Last/Org Name	Will be auto populated when the provider number is selected from the other provider list and then you hit the tab button on your keyboard
First Name	Will be auto populated when the provider number is selected from the other provider list and then you hit the tab button on your keyboard
MI	Not Required
Other Insurance Ind.	Is auto populated to N = no This may be changed to Y = yes if billing Medical Assistance as a secondary or co -insurance * please see attachment for further instructions when billing secondary claims

SRV

FIELDS	VALUE
From DOS	The date you treated the client
To DOS	The date you stopped treating the client for this billing
Revenue Code	Which is appropriate = same as Medicare
Billed Amount	Will auto populate when claim is completed
Units	The total units you are billing for
Basic Unit of Measure	Auto populated to UN = Units
Unit Rate	The dollar amount you are billing for the procedure
Procedure	This is the service you are billing for
Modifiers	If applicable